PERFORMANCE AGREEMENT

between

THE MINISTRY OF HEALTH SERVICES

and

THE PROVINCIAL HEALTH SERVICES AUTHORITY

APRIL 1, 2003 TO MARCH 31, 2004

BRITISH COLUMBIA

DATED: October 24, 2003

This is an agreement between the Provincial Health Services Authority and the Ministry of Health Services, setting out our mutual understanding of the respective expectations and performance deliverables for the three fiscal years, 2003/04, 2004/05, and 2005/06. It will be updated and renewed annually for a new three-year period. Deliverables in previous Agreements that have not been achieved remain in force unless changed or cancelled in writing.

Given that:

- The government is committed to providing high quality patient-centred care, improved health and wellness for British Columbians and a sustainable, affordable public health system;
- The government is committed to substantial restructuring of the health care system, while maintaining the priority of patient needs;
- The government expects the health authority to continue to meet the requirements of the various legislation, regulation and policy, remaining in force at April 1, 2003, subject to amendments made from time to time by the Government of British Columbia;
- The government has established directions in *A New Era for British Columbia* and provided strategic direction for the health system in *A Picture of Health*;
- Specific performance targets for the health system are set out in the 2003/04 - 2005/06 Service Plans of the Ministries of Health Service and Health Planning;
- The government has provided guidance to the health authority through the letter of expectation to the Chair of the Board from the Minister of Health Services, dated December 12, 2001;
- The government will monitor programs, services, and performance indicators to ensure compliance with the above direction and guidance;
- The health authority will continue to provide a broad range of health care and health protection services to meet the needs of its population such as those provided by its predecessor health authorities;
- The health authority will continue to provide comprehensive, accurate, and timely reporting (financial, statistical, program-related, and person-based), as required by the Ministries of Health.

The parties hereby specifically agree that:

The Ministry of Health Services, in conjunction with the Ministry of Health Planning, will:

1. Provide in writing, to the Provincial Health Services Authority, the amount and details of operating and capital asset funding allocated for the 2003/04 fiscal year, along with an estimate of future funding levels for the 2004/05 and 2005/06 fiscal years. This information will be provided following the approval by the legislature of Supplementary Estimates that increase the Ministryís approved 2003/04 budget.

2. Provide the total 2003/04 funding identified above by electronic transfer to the health authority, in 26 bi-weekly amounts. Funding allocations from other sources within the Ministries of Health will be communicated separately.

3. Provide to the health authority, within one month from receipt, an assessment of the 2003/04 - 2005/06 health service redesign plan and budget management plan as submitted by the health authority.

4. Share, on a quarterly basis with the health authority, reports containing the information the Ministry is using to monitor the performance of the health authority and provide, for each required performance measure, baseline measures and benchmarks, where available.

5. Consult with the health authority on issues relating to health system performance and resource allocations resulting from major changes to funding for the health system and on changes to this Agreement (specifically in 2003/04 to review the report of the Auditor General on the first Performance Agreement; and any new deliverables resulting from the First Ministersí Health Accord).

6. Provide direction and policy clarification where needed respecting the relative roles and responsibilities of the health authorities, including the Provincial Health Services Authority (PHSA).

7. Consult with the health authority on issues relating to the provinceís implementation of generally accepted accounting principles (GAAP) and the inclusion of health authorities in the government reporting entity (GRE).

The Provincial Health Services Authority will:

1. Develop and deliver to the Ministry of Health Services within four weeks of receiving details of operating and notional capital funding allocated for **2003/04**, a health service redesign plan for **2003/04 – 2004/05** and a corresponding budget management plan. The plans must conform to existing health care policy and standards. The budget management plan must be balanced over **2002/03** and **2003/04** in total, and balanced for 2004105.

2. Manage and deliver programs and services for the fiscal year ending March **31, 2004**, such that the operating results are equivalent to or better than those projected in the budget management plans. Additionally, the total equity (excluding externally restricted funds) at March 31, 2005, must be equal to or better than the total equity (excluding externally restricted funds) as at March 31, 2001.

3. Take action to achieve the objectives set out in the Priority System Performance Improvements shown in Schedule A, collaborating where appropriate with the Ministries of Health and other health authorities.

4. After consultation, agree to perform the additional actions outlined by the Ministries of Health in response to the health authorityís updated health **service** redesign plan and budget management plan, as specified in the Ministriesídassessment of the health authority plan.

5. Comply with all required changes in reporting requirements as a result of the provinceís implementation of **GAAP** and the inclusion of health authorities in the GRE.

In the event the assumptions regarding compensation contained in the Budget Management Plan (specifically Appendix B of the Instructions for Health Service Redesign and Budget Management Plansí letter of June 13, 2003) are materially altered as a result of changes in government policies or specific government actions, the parties to this agreement agree to renegotiate its terms, taking into account the impact of the altered assumptions.

Agreed to, on behalf of the Provincial Health Services Authority, by:

_____ Chair of the Board

_____ Chief Executive Officer

Agreed to, on behalf of the Ministry of Health Services, by:

_____ Minister of Health Services

_____ Deputy Minister

Dated: Jan 19, 2004 ~~2003~~

Schedule A

Priority System Performance Improvements

Definitions for Clarity

Indicators within Schedule A are defined in Appendix B (attached).

Targets will be interpreted as follows:

1. Unless otherwise specified, the base line year is 2001/02.
2. Percentage increases/decreases are not percentage point changes unless so specified.

1. ***Emergency Health Services***

THE PRODUCT DURING:

a) 2003/04 will be:

I. Implementation of recommended practices in major facilities* from the Short Term Task Group (STTG) Progress Report, issued in April 2003, that are determined to be high priority by the Steering Committee, including some performance indicators.
II. Completion of a long range planning study.

b) 2004/05 will be to:

I. Implementation of the rest of the recommendations in the STTG Progress Report that are determined by the Steering Committee to be of significant value.
II. Initiation of reporting to the Ministry of some emergency room performance indicators from major facilities.
III. Feasibility planning for the recommendations of the Long Term Planning Report.

c) 2005/06 will be: *To be determined.*

* Major facilities are those hospitals that are either the largest facility in a Health Service Delivery Area or have a volume of emergency room visits in excess of 25,000 visits per annum.

2. ***Surgical and Procedural Services***

THE PRODUCT DURING:

a) 2003/04 will be:

Completion of a provincial surgical services system plan that identifies the strategies and developments to be taken and the initial implementation of the elements of the system plan which are determined to be of greatest priority by the Steering Committee in supporting the surgical planning work of the health authorities. This will include surgical and procedural measures and standards where available (consistent with the Provincial Surgical and Procedural Services Review Project Terms of Reference, March 13, 2003).

b) 2004/05 will be:

I. The substantial implementation of components of the provincial surgical plan evaluated to be of highest value and benefit to the health authorities by the Steering Committee and evidence of indicators that will demonstrate the status of improvement of the performance of surgical services within health authorities.

II. The development/adoption of best practice in surgical services care and management which are determined to be of greatest benefit by the Steering Committee.

c) 2005/06 will be: *To be determined.*

3. ***Mental Health Services***

EXPECTED PERFORMANCE

Downsize Riverview consistent with the development of Riverview replacement units and the Mental Health Plan. Ensure the facility downsizing plan and budget management plan are consistent with regional development, as detailed in the regional health authorities' performance agreements.

Working closely with the MOHS, collaborate in the planning, coordination, monitoring, and evaluation of mental health services, consistent with the Mental Health Plan.

Continue to plan for the transfer of community Forensic Psychiatric clinics to the five regional health authorities, as proposed in the Mental Health Plan (carry forward from 2002/03), to occur after 2003/04.

4. ***Acute Care Services***

EXPECTED PERFORMANCE

a) In conjunction with the other health authorities, maintenance of benchmark waiting times for Chemotherapy - 90% of patients beginning treatment within two weeks of being ready to treat.

b) Maintenance of benchmark waiting times for Radiotherapy - 90% of patients beginning treatment within four weeks of being ready to treat

On behalf of MOHS, the PHSA will monitor chemotherapy performance in all health authorities.

5. ***Public/Population Health***

EXPECTED PERFORMANCE

a) Continued collaboration with all other health authorities and the Ministries of Health in the development of core prevention and protection programs, and in the review of literature and research of best practices and performance in other jurisdictions. Participation in consultations which began in 2002/03 has resulted in the development of a list of prioritized core programs for protection and prevention. Outcomes of this process will include:

I. In 2003/04, the development of core program delivery expectations and performance measures; and
II. In 2004/05, the incorporation of appropriate core programs into a new *Public Health Act*.

b) In 2004/05, comply with the requirements of the new *Public Health Act*.

c) In 2004/05 improve the performance of the core prevention and protection programs as measured by the indicators developed as above.

d) Immunization Rates - through the support and services of the BC Centre for Disease Control, assist the regional health authorities to achieve their expected performance targets to increase rates of immunization.

6. ***Support and Administrative Services***

EXPECTED PERFORMANCE

Reduce the annual expenditures for Support and Administrative Services (excluding Information Systems), by the 2004/05 fiscal year, by at least 7 percent of these expenditures incurred for the fiscal year 2001/02.

7. ***Physician Services***

EXPECTED PERFORMANCE

Cooperate in a Ministry-led process to clarify and introduce, within the existing Framework Agreement between the government and the BC Medical Association, the Ministry's expectations of health authorities for the management and reporting of physician services funded through the authorities.

APPENDIX A

PROVINCIAL HEALTH SERVICES AUTHORITY: MANDATE, ROLE AND ACCOUNTABILITY

MANDATE

The Provincial Health Services Authority (PHSA) is one of six health authorities in British Columbia. The PHSA mandate is to ensure effective and high-quality delivery of selected province-wide health care programs and services, either through directly providing them, or through ensuring that the programs are being appropriately provided through the regional health authorities.

The PHSA fulfils this mandate in a number of ways, including:

1. Assumes responsibility for the governance, management, and funding of selected agencies and organizations providing province-wide health care services.

2. Assumes responsibility, in a change management role, in collaboration with the Ministries for the development/enhancement of selected provincial programs and ensures that the changes required to achieve improved outcomes are effectively planned, implemented, monitored and evaluated.

   In certain instances (to effect required changes) assumes responsibility on behalf of the Ministry of Health Services (MOHS) for allocating funds for these programs for as long as province-wide system changes are being introduced.

   In conjunction with the MOHS, takes on longer term monitoring and evaluation of these services to ensure their continuous improvement.

3. Assumes responsibility for the coordination of a specific service if it is determined the service warrants a provincially coordinated approach to service delivery. This could include the administration of a number of smaller service contracts previously administered within the MOHS, where there is a clear provincial mandate and focus.

4. At the request of the MOHS, and in consultation with the regional health authorities, takes on additional roles related to province-wide, inter-provincial and/or international programs.

The MOHS and PHSA will have a performance contract and performance expectations for services the PHSA is required to provide through the agencies that it directly governs and manages. This performance agreement will also outline the expectations of the Ministry concerning the PHSA's planning and coordination role in the selected provincial programs.

KEY RESPONSIBILITIES

1. <u>Corporate Governance and Management</u>

The PHSA is responsible for governing, managing, and funding selected health care agencies, societies, and programs that provide province-wide services, and in ensuring the academic roles of these agencies are being properly addressed. In conjunction with its role in governing these organizations, the PHSA will also take a leadership role in planning and delivering specialized province-wide services in cancer control and treatment, renal, child health, women's health, mental health, and health prevention and disease control.

The constituent agencies of the PHSA are:

- BC Cancer Agency (BCCA)
- BC Centre for Disease Control (BCCDC)
  - BC Drug and Poison Information Centre
- BC Mental Health Society (Riverview Hospital)
- Forensic Psychiatric Services
- BC Provincial Renal Agency
- BC Transplant Society
- BC Children's Hospital and Sunny Hill Health Centre
- BC Women's Hospital and Health Centre (including BC Reproductive Care Program and Perinatal Database, and Tertiary Perinatal Services)

2. Coordinating the Development of Specified Province-wide Programs and Services

In addition to its governance and management role for defined province-wide services, the Ministry mandates the PHSA to provide a leadership role, in support of the Ministries of Health, in developing the most effective service delivery practices for specific programs and services. In this capacity, the PHSA will assume a leadership role in planning and coordinating changes required in these programs to have them more effectively delivered throughout the province and, in conjunction with the MOHS, will monitor and evaluate the change processes over time to ensure their continuous improvement.

Selected programs may be funded by PHSA on behalf of the MOHS as the most efficient mechanism on a permanent or temporary arrangement. Direct or contractual funding by PHSA permits targeted funding, tracking of expenditures, and utilization review that facilitates reallocation or other forms of reconciliation.

A consultative process will be undertaken in the fall of each year that will include the MOHS, the PHSA, and the regional health authorities. This process will focus on the identification of high priority programs and issues that need to be considered on a provincial basis over the next three years, and determination of the goals and expectations for those programs and issues. The Ministries will use this consultation process to formulate and determine the provincial priorities for the PHSA for the upcoming year(s), which will then be incorporated into the next MOHS Service Plan, and the Performance Agreements of the PHSA and the regional health authorities.

Criteria for Program Planning Leadership by PHSA

In determining in which of the programs the PHSA will serve in a "change management" role the following will be considered:

- There is a need for significant changes to the existing patterns or quality of delivery of a service, and these changes can best be introduced with a full scope of provincial coordination and leadership.
- There is a need for integration of all provincial components of a service to ensure that patients in all areas of the province are effectively and efficiently served.
- There is an emerging technology or pattern of practice that needs to be carefully evaluated, cost analyzed, and planned for deployment before being introduced on a province-wide basis.

In applying these criteria it is recognized that, in the longer term, as many services as feasible and appropriate should be provided and funded through the regional health authorities.

Longer-term Involvement in Program Leadership

In limited instances, it might be deemed appropriate by government to have specific services coordinated for a longer term on a province-wide basis, if it is determined the service:

- Warrants a coordinated, integrated network of support services and facilities.
- Has, or requires, a provincial vision, plan, standards, and benchmarks.
- Requires focused attention to resource development, because of existing limited skill sets or need to develop capacity.

The regional health authorities will be expected to consult with the PHSA on any proposed changes in programs and services the regional authorities deliver, if such changes might have an impact on a program or project that is being provided/coordinated by PHSA. No change in these services is to be undertaken until the regional authority has reviewed the potential impact with the PHSA and there is concurrence to proceed.

Emerging Technologies and Practices

There currently is considerable work being done on the assessment of new and emerging technologies at both the national and provincial levels. The PHSA will be mandated to support the review of current and emerging health service issues and technologies, in collaboration with the Ministries of Health. As this assessment role continues to develop it is anticipated the PHSA will work closely with the Ministries in identifying emerging technologies and determining the future direction (including funding) of the selected emerging health services and technologies. The MOHS and the PHSA will work together to clearly identify their respective roles in these functions.

As part of this assessment process consideration will be given to the appropriate scope of the proposed programs to be offered, the resultant service expectations and impact in each health authority. There also needs to be a recommendation as to whether services are to be provided directly by the PHSA or by other health authorities, and the extent to which the PHSA may be expected to provide ongoing monitoring of these selected emerging provincial programs.

3. Other Duties

There are a number of other provincially focused activities the Ministries of Health may request the PHSA to undertake on their behalf. This could include taking on a leadership role related to province-wide, inter-provincial and/or international health care patient, medical and/or education, and research planning processes and initiatives.

Appendix B
Definitions for Measures in Performance Agreement

Applicable to all measures:

- Unless otherwise specified, the base line year is 2001/2002.
- All percentage increases/decreases will be measured on a cumulative basis over the term of the agreement plus previous agreements.
- Percentage increases/decreases are not percentage point changes unless so specified.

3. ***Mental Health Services***

a) Increased use of needs-based and evidence-based best practices to achieve:

I. Decrease by 4 percent over three years (2002/03-2004/05), in the percentage of alternate level of care days spent by mental health and alcohol and drug clients (aged 15-64) in hospitals once the primary need for inpatient care has completed, specifically:

Performance Measure

Target 2002/03	Zero%
Target 2003/04	2% decrease over prior year
Target 2004/05	2% decrease over prior year

DEFINITION:

Number of patient days designated alternate level of care (ALC) for persons aged 15 to 64 years with a mental health or alcohol and drug diagnosis as a percentage of the total inpatient days for these clients.

Alternate level of care patients are those who no longer require acute care services but are waiting in an acute care bed pending completion of discharge arrangements or placement in an alternative service setting, such as a residential facility or community based services.

Mental health or alcohol and drug clients are defined as having primary diagnosis ICD-9 290-314, V61 or V62 for years prior to 2001/02 and for 2001/02 and following years the selected ICD-10 CA codes for mental health diagnoses as translated from ICD-9 (F00-F53, F55-F69, F84, F90-F99, G312, G442, R410, Z281, Z55-Z57, Z60-Z65, Z72, Z73).

CALCULATION:

Numerator – total number of patient days designated alternate level of care in hospitals within a health authority for persons aged 15 to 64 years with a mental health or alcohol and drug diagnosis as defined above.

Denominator – total number of acute, rehab, and alternate level of care patient days in hospitals within a health authority for persons aged 15 to 64 years with a mental health or alcohol and drug diagnosis, as defined above.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: Discharge Abstract Database

II. Improved continuity of care measured by the proportion of persons (aged 15-64) hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge:

Performance Measure

Target 2002/03	3% increase over prior year
Target 2003/04	3% increase over prior year
Target 2004/05	3% increase over prior year
Target 2005/06	Increase over prior year; target to be decided

DEFINITION:

Number of persons aged 15 to 64 years hospitalized for a mental health diagnosis that received at least one contact with a community mental health centre, fee-for-service psychiatrist or general practitioner within 30 days of discharge as a percentage of the total number of persons aged 15 to 64 years hospitalized for a mental health diagnosis.

Hospitalizations are based on inpatient separations (all levels of care) for patients aged 15 to 64 years.

Mental health diagnosis is defined by a primary diagnosis of ICD-9 290-314, V61 or V62 for years prior to 2001/02 and for 2001/02 and following years the selected ICD-10 CA codes for mental health diagnoses as translated from ICD-9 (F00-F53, F55-F69, F84, F90-F99, G312, G442, R410, Z281, Z55-Z57, Z60-Z65, Z72, Z73).

MSP visits are restricted to those with a diagnosis of ICD-9 290-314, V61, V62, 04A or 50B.

CALCULATION:

Numerator – number of hospital discharges for residents of the region aged 15 to 64 years with a mental health diagnosis as defined above who have a subsequent record of contact with a community mental health centre (as determined by the presence of a service record in CPIM or by the opening of a new care episode), a fee-for-service psychiatrist visit or fee-for-service general practitioner visit (as recorded in the MSP database) within 30 days of discharge. MSP visits are restricted to those with a diagnosis or ICD-9 290-314, V61, V62, 04A or 50B.

Denominator – number of hospital discharges for residents of the region aged 15 to 64 years with a mental health diagnosis as defined above.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Sources: Discharge Abstract Database (DAD), MSP fee-for-service database, Client Patient Information Management System (CPIM)

Note: Percentage of community follow-up may be underreported as not all service events are recorded in CPIM. Some regions do not report services at all.

A MSP service on the same day as discharge is not counted as a follow-up but a visit to a community health center is counted. If a psychiatrist and general practitioner visit are recorded for the same day, the psychiatrist visit is counted.

b) Increase towards benchmarks the proportion of mental health services received by clients (aged 15-64) in their own health authority (health authority of residence):

Performance Measure

Acute Care: (Cases)	Benchmark	-98% Vancouver Coastal and Vancouver Island -95% Interior and North -85% Fraser
Community Mental Health Services		
	Benchmark	-98% all health authorities

DEFINITION:

Number of mental health services received by clients in their own health authority as a percentage of the total number of services received by these clients. Services for acute hospitalizations are measured separately from services provided by mental health centres.

Mental health client is defined as a person aged 15 to 64 years:

- discharged from an acute hospital with a primary diagnosis of ICD-9 290-314, V61 or V62 for years prior to 2001/02 and for 2001/02 and following years the selected ICD-10 CA codes for mental health diagnoses as translated from ICD-9 (F00-F53, F55-F69, F84, F90-F99, G312, G442, R410, Z281, Z55-Z57, Z60-Z65, Z72, Z73); or
- having an open care episode in CPIM.

CALCULATION FOR ACUTE SERVICES:

Numerator – number of inpatient cases for persons aged 15 to 64 years with a mental health diagnosis residing in the health authority that are discharged from an acute hospital within the same health authority.

Denominator – number of inpatient cases for persons aged 15 to 64 years with a mental health diagnosis residing in the health authority that are discharged from an acute hospital anywhere in the province.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

CALCULATION FOR COMMUNITY SERVICES:

Numerator – number of open care episodes for mental health clients aged 15 to 64 years residing in the health authority that received their service from a mental health center within the same health authority.

Denominator – number of open care episodes services for mental health clients aged 15 to 64 years residing in the health authority that received their service from a mental health centre anywhere in the province.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: For Acute Services: Hospital Discharge Abstract Database (DAD)
For Community Services: Client/Patient Information Management System (CPIM).

4. ***Home and Community Care***

c) Increase the number of clients with high level care needs (IC2 and above) receiving services above the base number as of March 31, 2002, and increase the percentage of these clients living in their own home, rather than in a facility specifically:

Performance Measure	
Target 2003/04	2% increase over prior year
Target 2004/05	5% increase over prior year
Target 2005/06	To be determined. Benchmark to be developed in light of experience.

DEFINITION:

This measure consists of two parts: the first part reports the actual number of unique home and community care clients with high level care needs receiving services in their own homes; the second part measures the proportion of clients with high level care needs receiving services in their own homes.

Clients with high level care needs are defined as those with care levels IC2, IC3, and EC.

The percentage of clients with high level care needs receiving services in their own home is the number of unique home and community care clients classified as care level IC2 and above receiving home-based services divided by the total number of unique home and community care clients classified as care level IC2 and above that receive home-based or residential services.

Home-based services are defined as Adult Day Care, Home Support, Choice in Supports for Independent Living (CSIL), and Assisted Living.

Residential services include those clients receiving care in residential facilities, group homes and family care homes. Respite care, mental health group homes, mental health family care homes and mental health boarding homes are excluded.

CALCULATION:

Numerator – the number of unique home and community care clients assigned care level IC2 and above receiving home-based services. Clients are counted only once, even though they may be receiving more than one community-based service.

Denominator – total number of unique home and community care clients assigned care level IC2 and above receiving home-based or residential services.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

The baseline for the number of clients with high level care needs receiving services in their own home is March 31, 2002. The actual number of unique clients (as calculated in the numerator above) will be compared each year to the baseline.

Definition qualifiers – community care clients often receive more than one service so total number of unique clients receiving community-based services does not reflect the amount or range of service any one individual may receive.

Data source: Continuing Care Information Management System (CCIMS)

(NHA is not required to increase the number of clients, only the percentage)

d) Reduction of ALC days as percentage of total inpatient days by 17 percent over the four years 2002/03 - 2005/06:

Performance Measure

Target 2003/04	5% decrease over prior year
Target 2004/05	5% decrease over prior year
Target 2005/06	3% decrease over prior year

DEFINITION:

The number of days that Alternate Level of Care (ALC) patients spend in acute care hospitals, as a proportion of all inpatient hospital days.

Alternate Level of Care (ALC) patients are those who no longer require acute care services but are waiting in an acute care bed pending completion of discharge arrangements or placement in an alternative service setting, such as a residential facility or community based services. Starting April 1, 1999 Discharge Planning Unit (DPU) cases were no longer reported as a separate level of care. DPU patients are reported as acute level of care cases and the DPU days are identified on the discharge abstract as ALC. Due to this policy change, DPU days before fiscal year 1999/2000 are considered ALC days for calculation of this measure.

This measure is based on the workload measures of the facilities within each health authority and does not report the utilization of ALC days by the population of the health authority.

ALC days as percentage of total inpatient days is designed to provide information about whether patients have timely access to the most appropriate care setting. If many patients occupying acute beds could be more appropriately cared for in an alternative setting, this suggests issues with the availability of and access to alternative types of care, other difficulties with discharge planning or difficulties with the management of waitlists for residential care. It also suggests that management of acute care beds could be improved.

CALCULATION:

Numerator – total patient days designated as ALC for all the facilities within a health authority. Includes non-residents and excludes newborns and BC residents treated out of province.

Denominator – total inpatient days designated acute/rehab and ALC for all the facilities within a health authority. Includes non-residents and excludes newborns and BC residents treated out of province.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: Discharge Abstract Database

5. ***Acute Care Services***

a) Maintenance of benchmark waiting times for Chemotherapy – 90% of patients beginning treatment within two weeks of being ready to treat.

DEFINITION:

The proportion of patients receiving chemotherapy within two weeks of being ready to treat.

CALCULATION:

Numerator – the number of patients receiving chemotherapy within two weeks of being ready to treat

Denominator – the total number of patients receiving chemotherapy

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: BC Cancer Agency – Cancer Registry

Note: PHSA will monitor chemotherapy performance for all health authorities

a) Maintenance of benchmark waiting times for Radiotherapy – 90% of patients beginning treatment within four weeks of being ready to treat. *This is only in the PHSA agreement*

DEFINITION:

The proportion of patients receiving radiotherapy within four weeks of being ready to treat.

CALCULATION:

Numerator – the number of patients receiving radiotherapy within four weeks of being ready to treat

Denominator – the total number of patients receiving radiotherapy

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: BC Cancer Agency – Cancer Registry

b) Reduction in rates of May Not Require Hospitalization Admissions (Cases/1000)

Performance Measure

Target 2003/04	5% decrease over prior year
Target 2004/05	5% decrease over prior year
Target 2005/06	5% decrease over prior year

DEFINITION:

Rates of acute care admissions for conditions that could be managed outside the hospital.

The age-standardized rate of hospitalization in acute care facilities for conditions or procedures that have been identified by Canadian Institute for Health Information (CIHI) as belonging to a case mix group for which a typical patient's characteristics are suited to treatment as an outpatient.

May Not Require Hospitalization (MNRH) has traditionally been defined through set of Case Mix Groups (CMGs), a classification developed by CIHI. It is used to describe cases in which the combination of diagnosis, procedure and age usually mean that care could have been appropriately provided without the need for admission as a hospital inpatient. The MNRH CMGs are 55, 57, 63, 88, 89, 90, 91, 92, 93, 113, 114, 115, 116, 229, 232, 233, 234, 266, 271, 378, 379, 380, 381, 382, 409, 411, 413, 414, 512, 514, 534, 535, 536, 538, 554, 555, 563, 585, 586, 587, 596, 619, 791, 792, 793, 794, 795, 796, 797, 805, 852, 893, 906, and 909.

The implementation of ICD-10-CA and CCI in 2001/02 has impacted the CMG assignment. CIHI is currently examining issues related to CMG assignment. Until this work is complete, data for 2001/02 and subsequent years will not be available.

MNRH shows the extent to which services provided on an acute care hospital inpatient basis may have been provided appropriately on an ambulatory care basis. MNRH can be used as a utilization tool to identify potential opportunities to decrease inpatient admissions where appropriate. A decrease in the number of patients admitted to hospitals unnecessarily increases the efficiency (costs) and effectiveness (quality of service) of acute care facilities.

CALCULATION:

Numerator – total acute/rehab inpatient cases with a CMG designated as MNRH excluding newborns and non-BC residents, including BC residents treated outside of BC

Denominator – health authority population

The age-standardized rate is calculated using the indirect method standardized to the BC current year population.

Data Source: Discharge Abstract Database (DAD), PEOPLE (population estimates from Ministry of Management Services)

6. ***Public/Population Health***

d) Increased rates of immunization:

Performance Measure
Two year immunization: Percentage of two year olds with a completed series of immunizations in accordance with the routine childhood immunization schedule - National Benchmark 97%

Fraser and Vancouver Coastal

Target 2003/04 Submit a plan for 2004/05 on how the health authority will build capacity to monitor two year old cohort immunization coverage of the routine childhood immunization schedule.

Target 2004/05 Implementation of the monitoring plan for two year old immunizations. Commencing January 2005, and consistent with the approved plan, monitor the immunization rate for the two year old cohort.

Interior and Vancouver Island

Target 2003/04 Achieve a measurable increase, beyond 83%, toward the benchmark. Starting January 2004, measure two year old cohort with a completed series of immunizations in accordance with the routine childhood immunization schedule.

Northern

Target 2003/04 83% immunization rate. Starting January 2004, measure two year old cohort with a completed series of immunizations in accordance with the routine childhood immunization schedule.

DEFINITIONS:

Completed series of immunizations in accordance with the routine childhood immunization schedule:

4 doses of Diphtheria, Pertussis, Tetanus, Polio and Haemophilus Influenzae Type B;
3 doses of Hepatitis B;
2 doses of Measles, Mumps, Rubella.

Two year old cohort:

All children with their second birthday occurring in the same calendar year.

CALCULATION: (under review)

Numerator – the number of children in a one-month sample of children with their second birthday in April of a given year and from whom child health records (HLTH 182) are available who have completed a series of immunizations in accordance with the routine childhood immunization schedule as noted above.

Denominator – the number of children in the one-month sample of children with their second birthday in April of a given year and from whom child health records (HLTH 182) are available.

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: Data compiled centrally by Population Health and Wellness from the sample data collected by the health authorities.

Notes: BC Centre for Disease Control is conducting an extensive analysis of 2003 data.
Hepatitis B was added to the immunization schedule (for infants) in 2001.
The 2002/03 two year old cohort were the first to receive the vaccine as infants.
In 2004/05 this measure will be calculated based on annual data.
Complete definitions will be provided at a later date.

d) Increased rates of immunization:

Influenza immunization for residents of care facilities – Provincial Benchmark 90%.
Target 2003/04 Maintain 85% or more influenza immunization rate.

DEFINITION:

The proportion of residents of care facilities immunized for influenza in a given influenza season (October to February).

CALCULATION:

Numerator – the number of residents in care facilities immunized for influenza

Denominator – the total number of residents in care facilities

Percentage is calculated by dividing the numerator by the denominator and multiplying by 100.

Data Source: Data are submitted by health authorities (Annual Influenza and Pneumococcal Immunization Program Survey). Data compiled by Population Health and Wellness.

7. ***Support and Administrative Services***

Expected Performance

Reduce the annual expenditures for Support and Administrative Services (excluding Information Systems), by the 2004/05 fiscal year, by at least 7 percent of these expenditures incurred for the fiscal year 2001/02.

DEFINITION:

Most expenses incurred in a health authority are for services provided directly to patients. However, administration and support expenses represent monies spent on indirect services. Administration expenses are incurred through corporate services and the management of operations. Support expenses include monies spent on services such as health records, housekeeping, laundry, and food services. Other Administration includes administration expenses reported for Nursing Inpatient/Resident Services, Ambulatory Care, and Community and Social Services.

Support and Administration expenditures are identified using the Management Information System (MIS) functional centres. The calculation used here is consistent with the definition used in the reports on Administration and Support Expenditures distributed to Chief Financial Officers of the health authorities by Budget Coordination, Reporting & Accountability, Ministry of Health Services on March 21, 2002.

CALCULATION:

Support and Administration expenditures include the following MIS accounts:

Primary Accounts 711*

Administration Expenses
71205 (Nursing Inpatient Services)
71305 (Ambulatory Care)
71505 (Community)
and exclude:
71125 (Systems Support)

780* (Amortization of Software Licenses)
850* and 860* (Referred Out Services).

Data Source: Health Authority Management Information System (HAMIS).

8. ***Aboriginal Health***

Expected Performance

Improved status for Aboriginal people:

Performance Measure

Reduced infant mortality and increased life expectancy among Status Indians towards provincial non-aboriginal population levels.

INFANT MORTALITY RATE DEFINITION:

Infant mortality rate is the number of infants who die in their first year of life, expressed as a rate per 1000 live births. The rate for Status Indians is calculated in the same way using only the Status Indian population

CALCULATION:

Numerator – the number of Status Indian infants who die in the first year of life.

Denominator – the total number of live Status Indian births.

Status Indian births are defined as those births where either the mother or father is Status Indian. The registration of Status can take several years, thus confirmation of official registration is not required in the Vital Statistics records.

LIFE EXPECTANCY DEFINITION:

Life expectancy is an estimate of the average number of years that a person born in that year is expected to live, based on current mortality rates for a population. The Status Indian population is used to calculate this measure.

CALCULATION:

Life expectancy at age 0 represents the mean number of years a birth cohort (persons born in the same year) may expect to live given the present mortality experience of a population. The life expectancy for a population is a summary measure that reflects the mortality rate for all ages combined, weighted in accordance with a life-table population structure. For this measure, only the Status Indian population was used in the calculation.

Notes:

The Status Indian population is defined by Vital Statistics Agency using files from three sources: birth and death files from BC Vital Statistics Agency, the BC Medical Services Plan and the First Nations and Inuit Health Branch, Health Canada.
Status Indians were the only First Nations group that could be identified with these files, therefore this definition is not equivalent to the broader terms such as aboriginal or First Nations.

Population estimates for the non-aboriginal population are calculated using the provincial or regional population from PEOPLE and subtracting the Status Indian population as defined above.